FILING CLAIMS

TABLE 0F CONTENTS

Filing Claims

Claims

State Health Plan

The State Heath Plan (SHP) includes a hospital network, a physician network, an ambulatory surgical center network, transplant contracting arrangements, a prescription drug program and a program with participating mammography facilities. Participating SHP network providers accept the state's allowable amounts as payment-in-full and abide by the Plan's medical and surgical rules. Covered subscribers are responsible only for the deductible and coinsurance for covered services. Participating providers are obligated to file claims for SHP subscribers. Subscribers who show their health Identification (ID) card at participating pharmacies will only pay a copayment ($7 for generics, $22 for brand names or the cost of the prescription, whichever is less) for prescriptions for a 31 day or less supply. Filing a claim form for reimbursement for prescription drugs expenses will no longer be required. However, benefits will not be allowed for prescriptions purchased through non-participating pharmacies. The State Health Plan will not provide benefits for a pre-existing condition. Creditable coverage may be used to reduce a pre-existing condition limitation provided the prior coverage is continuous (prior coverage is considered continuous if the break in coverage is 62 days or less). Pregnancy does not constitute a pre-existing condition. Refer to the *Plan of Benefits Document* for additional information regarding pre-existing limitations under the SHP.

Filing a Claim to Blue Cross Blue Shield for Benefits

Network providers file claims for subscribers; however, to receive benefits when a hospital or doctor does not file, take the following steps:

- Complete the pink and white State Health Plan Comprehensive Benefits Claim form available from the Employee Insurance Program (EIP);
- Send the completed claim form, along with itemized bills that include dates of service and diagnosis, to Blue Cross and Blue Shield (BCBS) at the address on the back of the claim form. (The patient name must be identical to the listing on the Notice of Election form (NOE);
- Keep copies of all claims mailed and the name of any customer services representatives with whom contact is made;
- Allow three weeks to receive correspondence before calling either BCBS or EIP for assistance;
- File claims each time services are rendered;
- **BCBS must receive claims by the end of the calendar year following the year in which expenses are incurred. Otherwise, claims for those services will be denied**; and
- The member should notify his benefits office immediately of any address change. Remember, the member cannot use the claim form to make address changes.

Claim Denials and Appeals by BCBS

If a claim is denied by BCBS and the covered member is not satisfied with the decision*:*

- The member may request a review of the claim in writing to BCBS;
- The review should be requested through BCBS within six months from the receipt date of the denial;
- After the appeals process has been exhausted through BCBS (the member will receive correspondence from BCBS indicating the appeals options have been exhausted), an appeal may be requested through EIP within 90 days after notice of denial; and,
- After exhausting appeals through EIP, an individual may file an appeal with the circuit court within 30 days of receipt of notification of denial from EIP.

Filing a Claim for an Active Employee With Medicare

(Medicare must be secondary payer under the active group unless the employee or dependent is entitled to Medicare <u>solely</u> due to kidney dialysis or kidney transplant):

When an active employee and/or dependent have Medicare, claims are filed with BCBS first. Once the employee receives disposition, he should send an itemized bill and a copy of the SHP Explanation of Benefits to Medicare to be processed for secondary benefits. If an employee is entitled to Medicare solely due to kidney dialysis or transplant, contact Medicare for additional information.

Filing a Claim for a Retiree Group Subscriber With Medicare

- With the exception of prescription drugs not provided in an inpatient hospital setting, the claim must be filed with Medicare first, and the provider must file for the retiree;
- The pharmacist should file diabetic and ostomy supplies to Medicare first if the member is Medicare eligible;
- For retirees entitled to Medicare who refuse Medicare benefits, the SHP coordinates payment and claims as though Medicare has paid Part A and/or Part B benefits; and,

- Retirees not entitled to Medicare by their own record who become entitled by a spouse's record must enroll for Medicare when the spouse becomes entitled. If either refuses Medicare coverage, the SHP still pays as if they have both Part A and Part B benefits. The SHP assumes the retiree is entitled to Medicare regardless. Prior to Medicare entitlement, the SHP will pay primary for all claims.

Filing a Claim for Services Outside the United States

SHP benefits are allowed for covered services outside the United States. The patient probably will have to pay for the services and file claims for reimbursement. To file a claim:

- The patient needs an itemized bill or receipt with the name of the provider (doctor, pharmacy, hospital, etc.); the provider's Federal Tax Identification Number (if available); the patient's name and date of birth; the name and ID number of the subscriber; the date of service; the name of each service or procedure; the charge for each service or procedure in American dollars; and the name of the injury or illness (diagnosis). This applies only to Economy and Standard plan active and retired employees, including those entitled to Medicare**. Medicare does not pay for services outside the United States and neither will the retiree group Medicare Supplemental Plan.**
- **Always file SHP claims with BCBS. Remember BCBS must receive claims by the end of the calendar year following the year in which expenses were incurred or they will be denied**.
- Participation in Medi-Call is mandatory for services in the United States and Canada only. A list of services for which participation in Medi-Call is required may be found in the *state Insurance Benefits Guide*.

Coordination of Benefits (COB)

A person covered under more than one group health or dental insurance plan can file a claim for reimbursement from both plans. Claims for reimbursement under the SHP, Prescription Drug Program and State Dental Plan are subject to COB. If the member is covered under another group plan, claims should be filed to the primary carrier and then to the secondary carrier. COB for dependents covered under the SHP, State Dental Plan and Prescription Drug Program is governed by the Birthday Rule (refer to Plan of Benefits document). Medicare recipients currently do not need to file prescription drug claims with Medicare (Medicare does not currently pay for prescription drugs). To file a claim:

- The member will need a printout or receipt(s) from the provider, along with a copy of the Explanation of Benefits (EOB) from primary carrier (if applicable);
- The printout or receipt(s) should contain the name of the provider, Federal Tax Identification Number (if available); patient's name and date of birth, name and ID number of the subscriber; date of service, the procedure or service rendered and total charge; and,
- Reimbursement is limited to the Plan's allowable charge less the copayment, coinsurance or deductible amount. **Reimbursement for prescription drugs is not payable if a non-participating pharmacy is used**.

Subrogation (Right of Recovery)

The SHP is subrogated to the member's rights against a liable third party to the extent of benefits paid for medical expenses. Subrogation may occur:

- If an injury is the result of a third party, the Plan will seek compensation for medical expenses from the third party that caused the injury;
- If the member receives payment for medical expenses from another person, firm, corporation or business, the Plan may recoup in full for all medical expenses paid by the Plan;
- If the member settles a Workers' Compensation claim, the SHP will not pay benefits for the members' medical care; and,
- Refer to the ***Plan of Benefits Document*** (***Right of Recovery)*** for additional information.

State Health Plan Prescription Drug Program

The State Health Plan offers a prescription drug copay program. Members will show their health ID card at a **participating pharmacy** and pay a copayment ($7 for generics, $22 for brand names or the cost of the prescription, whichever is less) for a 31 day or less supply. **There are no claims to be filed** provided the member shows his ID card**.** The Prescription Drug Program benefits are the same for each State Health Plan: Economy, Standard and Medicare Supplemental. If the member forgets to show his health ID card to a participating pharmacist, full retail price may be charged and a claim for reimbursement (which will be limited to the Plan's allowable charge less the copayment) will have to be filed to Medco Health Solutions, Inc. **Benefits are not payable if a non-participating pharmacy is used**. Under the State Health Plan prescription drug program:

- Prescription drug costs will be carved out of a subscriber's medical coverage. This means that drug expenses will no longer count toward subscribers' annual deductible or the Plan's coinsurance maximum and will not accumulate toward the lifetime maximum benefit for other health benefits.

- Prescription drug benefits are payable without an annual deductible.
- The prescription drug plan will have an annual copayment maximum of $1,100 per person. If the copayments total $1,100, prescriptions will be allowed at no cost for the remainder of the calendar year at participating pharmacies.
- If a generic drug is available and a brand name medication is purchased instead, the benefit will be limited to the cost of the generic medication and the subscriber will be responsible for the difference in price. The difference does not apply toward the prescription drug plan's copayment maximum.
- Insulin will be allowed under the Prescription Drug Program and will be subject to the copayment amounts.
- Diabetic supplies co-pay will be $7 for a 31-day supply or less.
- Ostomy bags co-pay will be $22 for name brand, $5 generic for a 31-day supply or less.
- Durable medical equipment will continue to be payable under the SHP and claims should be filed with Blue Cross and Blue Shield using the pink and white health claim form (address on back of claim form).
- For prescription drug claim forms contact Medco Health Solutions, Inc., or EIP Supply. Remember, you must file for reimbursement within one year of the prescription dispense date.
- The SHP prescription drug program will coordinate benefits provided a SHP participating pharmacy is used.
- Voluntary mail service prescription drugs are also offered. Generic medication copayments are $16 and brand name medication copayments are $50 for up to a 90-day supply.

State Health Plan Prevention Partners Preventive Worksite Screening Benefit

- The Prevention Partners coordinator or BA mails or faxes a Worksite Screening Request form (Page 181) at least six weeks in advance to schedule a worksite screening. The coordinator or BA must provide the date, location, earliest starting time and approximate number of employees wishing to be screened on the form;
- Prevention Partners contacts the screening provider to confirm the date and location;
- Prevention Partners sends a confirmation notice and implementation kit to the worksite;
- Employees taking part in the screening write a check payable to the screening provider and gives that check to the coordinator or BA;
- Coordinator or BA collects employees' checks for the $15 copayment and schedules appointment times. Coordinator or BA faxes check receipt form and appointment schedule to Prevention Partners for eligibility verification;
- On the day of the screening, the coordinator or BA gives the employees' checks to the screening provider. The provider processes claims for the additional charges;
- After the screening results are complete, the provider will deliver confidential, individual results in sealed envelopes to the worksite coordinator or BA;
- Questions regarding worksite screenings should be directed to Prevention Partners at (803) 737-3820.

HMO

HMO participants do not need to file claims for services rendered within the service areas authorized by the primary care physician. Contact the HMO for information concerning coordination with Medicare.

State Dental Plan and Dental Plus Plan

Most dental offices file claims directly to Harrington Benefit Services. For those that do not file, the member must:

- Complete a dental claim form and mail it directly to Harrington Benefit Services along with the itemized bills. The patient's name should be identical to the listing on the NOE;
- Allow three weeks for claims to be processed;
- Direct any claims problems or concerns to Harrington Benefit Services;
- **Submit claims to Harrington Benefit Services no later than 24 months after services are incurred;**
- **Claims submitted more than 24 months after the service is rendered will be denied**; and,
- Claim forms may be obtained by contacting EIP Supply or website.

Dental Claim Denials and Appeals

If a claim is denied and the patient is dissatisfied:

- The member may request in writing a formal review of the claim by Harrington Benefit Services, Appeals Coordinator, 3401 Morse Crossing, Columbus, OH 43219;
- Review should be requested within six months of receipt of the denial;
- After exhausting appeals through Harrington Benefit Services, the member may file a written appeal to EIP within 90 days of the denial;
- After exhausting appeals through EIP, the member may file in circuit court within 30 days of receipt of notification of denial from EIP;
- Pretreatment estimates from Harrington Benefit Services must be returned with the claim after the services are rendered;
- The pre-certification is valid for one year from the date on the Predetermination of Benefits form.

Basic Life ($3,000) and Dismemberment
File claims through The Hartford, Group Benefits Division, Suite 275, The Siskey Building, 4521 Sharon Road, Charlotte, NC 28211. Claim forms may be obtained from EIP Supply or website.

Optional Life

Optional Life Benefits: $10,000 to $300,000

- Complete Part One of Proof of Death form-form # LC-6503-2;
- Include BA's signature, date form completed, and address of agency, school district or local subdivision;
- Indicate if accidental death and attach copy of police report, newspaper article, etc. Accidental death will pay double indemnity;
- Indicate if seat belt rider applies and attach copy of police report, newspaper article, etc. Seat belt rider will pay additional 10 percent of accidental death benefit;
- Send the white copy of Proof of Death form to The Hartford. Attach a copy of the NOE with the current level of coverage and beneficiary information, a certified, raised-seal death certificate, and any other pertinent documentation. The Hartford will mail payment to the beneficiary with notification to the BA and EIP;
- Send the yellow copy of the Proof of Death form to EIP with a non-certified copy of death certificate;
- Complete Active Termination NOE canceling coverage;
- Allow at least 10 working days before checking the claim status if it is an uncomplicated claim. Problem claims, accidents and homicides require an in-depth investigation. Payment is determined after the investigation is complete;
- The Hartford is not responsible for the validity or tax consequences of any assignment;
- No assignment will be binding on The Hartford until The Hartford records and acknowledges it;
- Collateral assignments are not permitted;
- Method of payment by The Hartford is lump sum, unless another method is requested and The Hartford agrees to in writing; and,
- EIP will maintain records of death claim payments and monitor death claims pending more than 60 days.

Subscriber Death – Other Notifications

- Notify the South Carolina Retirement Systems (SCRS) regarding SCRS benefit check, if applicable;
- File for LTC Return of Contributions with Aetna if the deceased was an active employee enrolled in LTC coverage at the time of death;
- File for SLTD with the Standard Survivor benefits if the deceased was an active employee enrolled in SLTD coverage at the time of death;
- Complete an NOE to terminate the coverage as soon as the death is confirmed and mail it to EIP; and,
- Claim forms may be obtained from EIP Supply or website.

Retirees not Under Waiver of Premium

Call The Hartford at 1-888-803-7346. The necessary claim form will be forwarded to the correct party for completion.

Accidental Death Benefits

- The claim form for accidental death benefits is the same form used for Optional Life benefits;
- Complete the claim form as instructed, listing the face value amount of the coverage (which doubles in the event of accidental death);
- The word "accidental" must be written in the *Remarks* section to process a claim for accidental death benefits;
- Although the certified death certificate indicates the cause of death, a copy of the police report, incident report and/or a newspaper clipping must accompany the claim form; and,
- **Suicide is a covered life claim; however, double indemnity benefits are not payable**. Effective Jan. 1, 2001, no Optional Life benefit is payable if death results from suicide, whether sane or insane, within 2 years of the effective date. If death occurs within 2 years of the effective date of an increase, the death benefit payable is limited to the amount of coverage in force prior to the increase.

Dismemberment Benefits

There are separate forms for dismemberment in the event of the loss of a limb or eye. Request the dismemberment claim forms as needed. A very limited supply is printed because of limited usage. Refer the employee to the *Insurance Benefits Guide* for the percentages paid according to the loss. Send a copy of the dismemberment claim to EIP. Depending on the dismemberment, the employee may file a claim for disability as well.

Complete Page 1 of The Hartford Statement of Claim for Accidental Dismemberment or Loss of Sight Benefit form-#LC-6504-2;

- Include the employee's and a witness' signature, and the date the form is signed;
- A physician must complete Page 2 of the *Statement of Claim for Accidental Dismemberment* or *Loss of Sight Benefit* form;
- Include the physician's signature and address;
- Send original form to The Hartford;
- **Send a copy of the form to EIP** and,
- Contact EIP Supply or website for claim forms.

Seat Belt Rider

Benefits will be determined based on the death certificate and/or incident report. **Send a copy of the claim to EIP**.

Living Benefit Option

The living benefit option allows an employee to receive up to 80 percent of his Optional Life benefit prior to death when diagnosed by a physician as terminally ill with a life expectancy of 12 months or less.

- Complete Page 1 of the *Living Benefit* form - #LC-6966-0;
- Include the employee's and a witness' signature;
- A physician must complete Page 2 of the *Living Benefit* form;
- Include the physician's signature, degree, and address;
- Complete the Consent form for Payment of Living Benefits;
- Include the employee's signature and the date signed;
- Include a Notary Public's signature and seal;
- Send the original copy of the form to The Hartford;
- **Send a copy of the form to EIP**; and,
- If terminating employment, see *Terminations*.

Additional Disability Options

- If leaving due to disability, complete the Optional Life waiver premium form, if applicable;
- Explain the Optional Life portability or conversion options, if applicable;
- Refer to the SCRS, if applicable;
- Refer to Aetna regarding LTC waiver of premiums, if applicable;
- If Standard Insurance Company BLTD and SLTD forms have not been filed, contact EIP; and,
- Claim forms may be obtained from EIP Supply or website.

Dependent Life Benefits

- Complete Part Two of The Hartford Proof of Death form #LC-6503-2;
- Include the BA's signature, the date the form is completed, and the address of your agency, school district or local subdivision;
- Send the white copy of Proof of Death form to The Hartford. Attach a copy of the NOE with current level of coverage and beneficiary information (the employee is automatically the beneficiary of any covered dependent who dies), a certified raised seal death certificate, and any other pertinent documentation;
- Send the **yellow copy of the Proof of Death form to EIP with a non-certified copy of death certificate** and copies of any other pertinent documentation;
- Give the employee an NOE to complete. If the dependent was the last eligible dependent and the level of coverage is affected by the dependent death, the employee has 31 days to complete the coverage change;
- If coverage is not affected, to delete the dependent's name, the employee must still complete, sign and date an NOE;
- File for LTC with Aetna for Return of Contributions if the deceased is the spouse of an active employee and was enrolled in LTC coverage at the time of death;
- Homicides require in-depth investigation;
- Payment is determined after the investigation is completed; therefore, it may take more than 10 working days;
- **Dependent Life child does *not* pay double indemnity for accidental death**; and,
- Contact EIP regarding claim forms.

MoneyPlu$ Benefits
Dependent Care Spending Account and Medical Spending Account:

The claims procedure is very simple. After all, employees are asking to be reimbursed with money they set aside pretax. Claim forms are produced with two parts:

- Stanley, Hunt, Dupree, Rhine & Associates, Inc. (SHDR) copy and the employee's copy. The employee keeps his copy of the claim and the original receipts for his records;
- Copies of receipts or a provider statement of expense must be attached to process the claim;
- The dependent-care provider may sign the claim form where indicated in lieu of a receipt;
- Employees **always** should print their name; SSN; a description of the expense; the person for whom it was incurred; the month, day and year incurred; and the amount;
- Only the expenses an employee is obligated to pay may be claimed;
- The employee may use the last day of a period in which expenses were incurred. For example, day care for the entire month of January may be submitted as January 31;
- Each week, SHDR processes accumulated claims and sends checks to each employee;
- SHDR is required to process and pay all claims for which funds have been posted within five working days;
- Payroll deduction data from the employer is submitted to SHDR after payroll processing. So, if an employee submits a day-care claim before SHDR receives the payroll data, the claim is processed without any money in the account. This results in a suspended claim, which is paid within five working days after the payroll data arrives. A suspended claim results also when an employee incurs day-care expenses for more than their account balance. A check for the balance is issued. Additional checks are written as the payroll data arrives;
- Medical Spending Account checks are written weekly for the full amount of the claim, regardless of the employee's account balance, up to the unused portion of the elected annual deduction;
- During the plan year, the minimum check written is $30;
- At the end of the plan year, a minimum check amount is not observed so employees can submit sufficient claims and clear their balance;
- The employee files directly with MoneyPlu$ and may file as often as he wishes during the calendar year;
- Give the employee the reimbursement claim form;
- The employee completes the form and attaches the itemized bills, explanation of benefits and/or the itemized receipt;
- The employee is responsible for filing during the calendar year;
- **Benefits not used by December 31 and not filed for by March 31 of the following calendar year are forfeited to the plan by federal mandate**;
- MoneyPlu$ claim forms maybe obtained by contacting EIP Supply or website; and,
- For Medical Spending Dependent Care Account inquires contact SHDR.

Long Term Care
Filing a Claim

If a plan participant believes he is eligible for benefits, a call to Aetna's LTC hotline at 1-800-537-8521 (8:00 a.m. to 4:00 p.m. EST Monday through Friday) initiates the five-step claim process:

- Calls are referred to Aetna's LTC Case Management Unit. The unit is staffed by registered nurses and master's level social workers who specialize in long term care management and are familiar with the South Carolina plan;
- The case manager takes the claimant's name, address, telephone number, SSN, policyholder name, a brief description of current medical status, and the reason for the claim. The case manager also briefly reviews the claim process;
- The case manager then verifies the claimant's eligibility in Aetna's records and sends out a Benefit Request form to be completed by the claimant and his physician;
- When Aetna receives the form, a case manager is assigned to handle the claim. A criterion for determining benefit eligibility is functional disability based on the claimant's ability to perform activities of daily living. Loss also may be caused by cognitive impairments not linked to activities of daily living. The case manager coordinates and evaluates information about the functional incapacity or cognitive impairment and the projected course of the illness or injury, based on input from the claimant and his family, physician and other health providers;
- No physical examination is required as part of the claim process. The claim evaluation usually includes an interview with the claimant by telephone, and in some cases involves an on-site visit by a registered nurse or a social worker to determine the person's level of incapacity. There is no charge for on-site visits;
- The claimant is notified in writing of the claim determination and payment is initiated if approved;
- If the claim is not approved, the claimant can request in writing an appeal within 60 days of receipt of claim determination letter. Regardless of the condition and/or the existence of prior claims, even if denied, a claimant can initiate the claim process at any time;

- If the claim is approved, benefits are paid at the end of each month. No bill is required from a provider. The claimant can assign payments to a provider when the daily benefit is less than or equal to the daily charge;
- Once benefit payments begin, the case manager periodically contacts the claimant to check on any changes in the case, to help assure the care is appropriate for the claimant, and to address any questions or concerns; and,
- Eligibility or claim concerns should be directed to Aetna.

Claims Denials and Appeals

Aetna's claim appeal process follows Employee Retirement Income Security Act (ERISA) requirements. If a claim is denied, the decision is made and communicated within a reasonable period (in most cases, no more than 90 days). The notice of denial states:

- the specific reason(s) for the denial;
- a reference to the plan provisions on which the denial is based;
- a description of additional information or material that may reverse the denial decision and why it is necessary; and,
- how to submit the claim for review.

ERISA requires that a review procedure be in place for appealing denied claims. The claimant's denial letter will include the information about obtaining a review.

- The claimant should submit a request for review, in writing and within 60 days of the denial, to the office where he originally submitted the request for benefits;
- The request should include the claimant's name, SSN, identifying information from the denial letter, and the issues and comments to be considered;
- The claimant may review documents pertinent to the claim;
- The claimant will typically receive notification of the final claim review decision within 60 days of the request; and,
- The final claim review decision is reviewed by the Executive Claim Committee, which consists of representatives from Aetna's medical, legal and claim administration departments.

Disability Retirement

- An employee files an application for disability retirement benefits through the South Carolina Retirement Systems (SCRS) as soon as a physician confirms that the condition will extend more than 30 days;
- If the employee is unable to file, the employer may file for him;
- The process always can be canceled if the condition does not exceed 90 days; and,
- Please contact SCRS at 803-737-6800 in Columbia, or 1-800-868-9002 outside Columbia for full details on disability retirement.

Basic Long Term Disability/Supplemental Long Term Disability (Policy #621144A)

- Give the claim form to the employee. Forms should be completed as soon as it appears likely that the employee will be disabled beyond 90 days. Employees may work part time or modified duties and still be eligible for benefits;
- Give employees applying for BLTD benefits a BLTD Certificate of Coverage;
- The employee completes the employee portion; the employee's doctor completes the physician's portion;
- The employee returns the form to you to complete the employer's portion;
- Mail the form to Standard Insurance Company; and,
- If Standard approves the employee for SLTD benefits, complete the State Optional Life and SLTD Premium Waiver form and forward it to EIP. The employee's premiums are waived while SLTD benefits are payable.

When the BA Should Call Standard

- Notify Standard Insurance Company at 1-800-628-9696 when you become aware of any of the following events concerning employees receiving SLTD and/or BLTD benefits:
- Employee returns to work;
- Employee dies;
- Employee is terminated;
- Employee receives deductible income (SCRS disability or retirement benefits, Social Security disability or retirement benefits, Workers' Compensation benefits, sick leave or shared leave, etc.); or
- If the employee has questions concerning the BLTD or SLTD coverage.

Checklist for Mailing Claims

- ❑ Make sure you are using the proper form. Health has two forms: A pink and white form for health claims and all physician's claims if the physician is not listed in the network;
- ❑ Be certain that each required section has been completed and the information is legible and correct;
- ❑ For prescription drug claims, tape all receipts to the Prescription Drug Reimbursement form or attach a pharmacy computer printout;
- ❑ Keep a photocopy of the claim;
- ❑ Make sure the patient's name is listed exactly as on the NOE;
- ❑ Ensure that the SSN of the employee/retiree is used for himself and all covered dependents. The providers use individual Medicare numbers when filing for health benefits through Medicare, with Medicare as the primary carrier;
- ❑ Attach proper and complete documentation;
- ❑ Use the correct carrier address;
  - ❑ For health claims (the pink and white form): State Health Plan Customer Services, BCBS of South Carolina, P.O. Box 100605, Columbia, SC 29260-0605;
  - ❑ For pharmacy claims: PAID Prescriptions, L.L.C., PO Box 2187, Lees' Summit, MO 64063-2187;
  - ❑ For dental claims: Harrington Benefit Services, Inc., Employee Benefit Administration, P.O. Box 268902, Oklahoma City, OK 73126-8902;
  - ❑ For disability retirement claims: South Carolina Retirement Systems, P.O. Box 11960, Columbia, SC 29211-1960;
  - ❑ For Optional Life and Dependent Life claims: ORIGINAL claim form to The Hartford Life Insurance Company, P.O. Box 2818, Hartford, CT 06101-5302; yellow copy to EIP, P.O. Box 11661, Columbia, SC 29211;
  - ❑ For Basic LTD and SLTD claims: Standard Insurance Company, Group Benefits Department, P.O. Box 2800, Portland, OR 97208-9929;
  - ❑ For LTC: contact Aetna at 1-800-537-8521;
  - ❑ For Basic Life: The Hartford, Group Benefits Division, Suite 275 The Siskey Building, 4521 Sharon Road,
  - ❑ Charlotte, NC 28211 and,
  - ❑ For MoneyPlu$: Stanley, Hunt, Dupree, Rhine & Assoc., Inc., MoneyPlu$, P.O. Box 16000, Greenville, SC 29606-0001.

HEALTH INSURANCE

Survivor Benefits

- A spouse or dependent child covered as a dependent of a subscriber (active or retired) who dies is classified as a survivor. A survivor can continue health and dental benefits through the state. (Refer to the section "Survivor Coverage Rules" Page 141)

Premium Waiver

- The **health insurance premium** for covered dependent survivors of employer-funded (active and retired) subscribers is waived for one year after the death of an employee or a retiree.
- Employer-funded means the employer is paying the employer premium for benefits.

LONG TERM CARE

Premium Adjustments

- If LTC insurance premiums for South Carolina are adjusted on a class basis for all plan participants, these adjusted rates will be passed on to all plan participants.
- Premiums also will change for those who increase their benefit option. **The cost of the additional coverage will be based on the attained age at the time of purchase.** The new premium includes the original premium plus the cost of any additional units of coverage purchased at the later age.

Premium Waiver

- Premiums will be waived upon satisfying the waiting period.
- Premium payments will resume on the first premium due date following the date the individual is no longer in a benefit period.
- Premium payments will continue for any other covered family members, such as a spouse, parents or parents-in-law, not in a benefit period.

Portability

- Coverage is portable. If an insured person is no longer eligible as an active employee or if the group contract is discontinued, coverage may be continued on a direct-billing basis. Parents also may continue coverage.
- Any election to continue coverage under this plan on a portable basis must be made within 31 days of the date coverage would otherwise terminate. Individuals electing portability will be billed directly or may pay premiums via electronic funds transfer (EFT) from their checking account.
- Retirees will be continued through EIP. If the employee is not retiring, continuation will be through Aetna.

SUPPLEMENTAL LONG TERM DISABILITY

Premium Waiver

- An employee's SLTD insurance will continue without payment of premiums while SLTD benefits are payable.
- Standard notifies EIP, BA and subscriber of approval. EIP initiates premium waiver in system. A system- generated letter will be mailed to the BA when EIP processes the waiver. BA should notify EIP if and when subscriber returns to work.
- To terminate the premium waiver upon the employee's return to work, the BA should complete the SLTD Premium Waiver form on Page 178 and forward it to EIP or return the system generated letter indicating the date the employee returned to work.

OPTIONAL LIFE
Disability Waiver of Premium: Disability Retirement, Basic LTD, Supplemental LTD

- If an employee takes a leave of absence due to a total disability (as determined by the entity), his Optional Life coverage will be continued for up to 12 months from the last day worked and the premiums will be waived for that period.
- If an employee retires during the 12-month waiver period, he should continue the coverage under the active group until the 12-month waiver period ends. The waiver does not carry over to the portability coverage. He should file for portability within 31 days of the date his waiver ends.
- If an employee dies during the 12-month waiver period, the benefits administrator will complete death claim forms for Optional Life. Send the original with a copy of the certified (raised seal or red seal) death certificate and Notice of Election to The Hartford. **Send the yellow copy with a copy of the death certificate to EIP. Keep pink copy for your records.**
- Complete Active Termination Notice of Election and file with copy of death claim to EIP to terminate waiver
- If an employee makes an attempt to return to work during the 12-month waiver period, works full-time for one full week, his Optional Life should be reinstated with premium. If he then must leave employment again, the 12-month waiver period will begin from the second date last physically at work. If an employee makes an attempt to return to work during the 12-month period, works part-time or works less than one full week then must leave employment again, the original 12-months waiver will continue
- A disabled state employee may be added as a dependent under his spouse's state health and dental coverage; however, he is not eligible for Dependent Life coverage until the 12-month Optional Life premium waiver period ends.

General Death Payment Rules
Policy Number GL33913

Active Subscribers

- Collateral assignments are not permitted and there is no cash value;.
- Benefits may be assigned by the beneficiary at the time of the employee's death;
- The beneficiary may choose payment in either a lump sum or installments;
- Benefits designated for a minor beneficiary are not paid until there is a court-appointed guardian. The carrier will hold benefits in a trust until the child is 18 years of age if arranged with the carrier beforehand;
- An executor or administrator must be appointed prior to payment when an estate is the designated beneficiary;
- An employee accidentally injured independent of sickness and all other causes is paid accidental dismemberment benefits as listed:
  - both hands, feet or eyes = principal;
  - one hand & one foot; one hand & one eye; or one foot & one eye = principal;
  - hand, foot or eye = one-half principal; and,
  - thumb and index finger of same hand = one-fourth principal.
- Payment at the face value of the policy is made for suicide provided coverage has been in effect for two years. Accidental death benefits will not be paid;
- In the event of homicide or accidental death, newspaper clippings, accident reports, coroner reports and/or court records are required prior to payment of the claim.

Process

- Complete death claim forms for Basic Life (Standard Insurance Company) and/or Optional Life (The Hartford), if applicable. Send the original with a copy of the certified (raised seal or red seal) death certificate and Notice of Election to The Hartford. **Send the yellow copy with a copy of the death certificate to EIP. Keep pink copy for your record**;
- Complete Active Termination Notice and file with EIP; and,
- Send COBRA notification to surviving dependents if applicable.

Dependents of Active Subscribers

- Complete death claim form for The Hartford, if applicable (refer to above procedures); and,
- Have subscriber complete Active Notice of Election adjusting current coverage, if applicable.

Retired Subscribers
Death benefits for first 31 days after retirement

- If an employee and/or dependent dies within the 31-day period in which he is entitled to have a conversion policy issued, the amount of group life insurance the employee was entitled to continue or convert will be paid to the designated beneficiary.

Process

- Complete death claim forms for Basic Life and/or Optional Life, if applicable;
- Complete Active Termination Notice and file with the EIP;
- If death occurs after the 31-day period, benefits will not be paid unless the employee submitted an application and the premium for the conversion and/or portability policy to The Hartford Life Insurance; and,
- In the case of a living benefit, if the claimant lives beyond 12 months, the remaining percentage can be ported if the claimant has retired. Otherwise, the remaining percentage can be converted.